NC Department of Health and Human Services

Division of **Medical Assistance**

north carolina medicaid

Care Coordination for Special Health Care Populations
Community Guide

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Targeted Case Management & Care Coordination

- **Targeted Case Management**
  - 42 Code of Federal Regulations (CFR) 441.18(8)(i) and 441.18(9))
  - Provider Service: not covered under the 1915 b/c waiver
  - 4 Billable Functions
    - Assessment
    - Planning
    - Linkage/Referral
    - Monitoring
- **Care Coordination (CC)**
  - Hands-on administrative function that enables the MCO to assure recipient access to appropriate care
  - 42 CFR 438.208(c)
  - Required for "Recipients with Special Health Care Needs"

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Care Coordination for "Recipients with Special Health Care Needs"

- **Intellectual/Developmental Disabilities**
  - Individual w/ I/DD (on Innovations or eligible for Innovations not living in a ICF)
  - Individuals with IDD in a facility operated by DOC or DJJDP & about to be discharged
- **Children with MH**
  - Child w/serious emotional disturbance (SED) & CALOCUS score of IV or more
  - Child w/SED in DJJDP or DOC facility with imminent discharge
- **Adults with MH**
  - Adults w/serious persistent mental disorder (SPMI) and LOCUS VI

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Care Coordination for "Recipients with Special Health Care Needs"

- **Substance Dependent:**
  - Individuals with a substance dependence and current ASAM PPC Level of III.7 or II.2-D
- **Opioid Dependent:**
  - Individuals with an opioid dependence diagnosis AND who have reported to have used drugs by injection within the past thirty days
- **Co-occurring Diagnoses:**
  - Individuals with both a MH and SA diagnosis and AND current LOCUS/CALOCUS of V OR current ASAM PPC Level of III.5 or higher
  - Individuals with both a MH diagnosis and an IDD diagnosis AND current LOCUS/CALOCUS of IV
  - Individuals with both an IDD and SA diagnosis AND current ASAM PPC Level of III.3

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Care Coordination
(42 CFR 438.208(c))

- Assess to identify any ongoing condition that requires a course of treatment or care monitoring
  - Assessment mechanisms must use appropriate health care professionals, including the primary care physician
- Produce a treatment plan
  - Plan must indicate what the recipient requests
  - Care Coordinator must educate recipient on benefit package
- Allow enrollees to access specialists
- Use Continuous Quality Improvement Process
  - To ensure that individual treatment plans are developed consistent with 42 C.F.R. Part 438.208 (above)
  - To ensure Enrollee participation in the treatment planning process

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Care Coordination Responsibilities—Overview of DMA Contact

- Education about all available MH/SA/DD services and supports
- Education about all types of Medicaid-funded services
- Linkage to needed psychological, behavioral, educational, and physical evaluations;
- Assist with development of the ISP or PCP
- Monitoring of the ISP, PCP, and health and safety of the recipient; and
- Coordination of Medicaid eligibility and benefits
- Coordination of care with each enrollee's PCP/CCNC physician /HealthHome

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NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Care Coordination—Population Management (DMA Contract)

- 24/7 crisis triage & assessment
- Coordination and monitoring of hospital and institutional admissions and discharges
- Follow-up activities to :
  - Enrollees who do not appear for scheduled appointments
  - Enrollees for whom a crisis service has been provided as the first service (ED, FBC)

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NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

What does the I-DD Care Coordinator Do?

The Roles and Responsibilities of Care Coordination are:

- Provide education on waiver services and rights and responsibilities for waiver participation
- Facilitating Person Centered Planning (annually)
  - Includes the participant, the participant's family, key providers, the community Guide, and others to develop the Individual Support Plan (ISP)
  - The CC develops the plan and the long range goals
  - The providers develop short range outcomes
  - Development of a budget in coordination with the ISP
  - Identify risks to ensure that they are addressed in the ISP
  - Identify how emergency & back-up services will be furnished

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What does and I-DD Care Coordinator Do? Cont'd

- Assisting the participant with the identification of service providers
- Assuring access to specialized assessments
- Coordinating services with the participant's Community Care of North Carolina (CCNC) medical home
- Arrange other Medicaid services
- Monitoring the participant's care to assure quality, the continued appropriateness of services, and the health, safety, and well-being of the participant is met
  - Face to Face visits, telephone calls, and review of service documentation

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What does and I-DD Care Coordinator Do? Cont'd

- Recognizing and reporting critical incidents
- Assisting with filing grievances
- Provide an Orientation to Individual and Family Directed Supports
- Referring the participant for Community Guide Services

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What is a Community Guide?

Community Guide Services are:

- Supportive and assistive rather than directive and management based
- As the participant's community connections develop and skills increase, Community Guide services should start fading unless additional support needs are identified

A Community Guide provides support to the participant and his / her planning team to:

- Develop Social Networks and connections within the local community.
- Promote Self-Determination.
- Increase Independence, and
- Enhance the participant's ability to interact with and contribute to his/her community.

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What does a Community Guide Do?

- Assist with both locating and accessing non-Medicaid community supports / resources related to ISP outcomes. This can be social, educational, and natural resources
- Support the participant with locating and accessing social networks and community organizations to build connections
- Advocate and collaborate with other individuals and organizations on behalf of the participant
- Support the person in preparing, participating in and implementing plans of any type (IEP, ISP, or service plan)
- Assistance in locating options for renting or purchasing a personal residence.
- Assistance with purchasing furnishings for the personal residence
- Assisting the participant with locating transportation options
- Providing training & assistance on the Individual and Family Directed Supports Option

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